

presentation to:

# **Medical Assistance Projections and Assessment Council**

by:

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**Iowa State Capitol**

# **Goals Regarding IowaCare**

- **Make sure that IowaCare can fulfill its objectives:**
  - **Provide needed health services to vulnerable and otherwise uncovered/unserved populations**
  - **Draw down \$65 million in federal Medicaid funds that otherwise would have been lost**
  - **Maintain the integrity (fiscal and programmatic) of existing institutions serving vulnerable populations**
- **Incorporate into the overall Medicaid program only those features of IowaCare that have proved effective and are applicable to Medicaid's overall population**

# **Major Areas of Concern Regarding Current IowaCare Structure and Start-up**

- Capacity to draw down \$65 million in federal funds and implications to institutions and the Medicaid program if it does not
- Lack of coverage of pharmaceuticals
- Understanding of program and its benefits and limitations to public and to consumers
- Implications of premiums and co-payments to individual participants' ability to pay and to their health
- Implications of premiums on enrollment and draw-down of federal funds

# **IowaCare Members Disenrolled Effective October 1, 2005**

Premium Range	Number Disenrolled
\$ 1 - \$10	173
\$11 - \$20	134
\$21 - \$40	49
\$41 - \$50	84
\$51 - \$60	70
\$61 - \$70	22
\$71 - \$75	9
Total Disenrolled	541
Total Enrollment	10,965
Percent Disenrolled	4.93%

# **Need for Ongoing Review: Short Term Study**

**At least a preliminary phone survey or interview of a random group of 50 disenrolled individuals to determine the health situations that caused them to enroll, their experiences with the program in receiving services, and their reasons for leaving**

# **Need for Ongoing Review: Long Term Study**

- **Study analogous to the “welfare leavers” studies used to determine the impact of the TANF provisions on families**
- **How does IowaCare fit within the broad goal of meeting health care needs of those without health insurance?**
- **How accessible is IowaCare?**
- **What needs is IowaCare meeting?**
- **What needs is IowaCare not meeting?**
- **Are other Iowa health care programs addressing unmet needs?**
- **What is needed to fill the gap?**

# **Implications for Children of IowaCare Experiences**

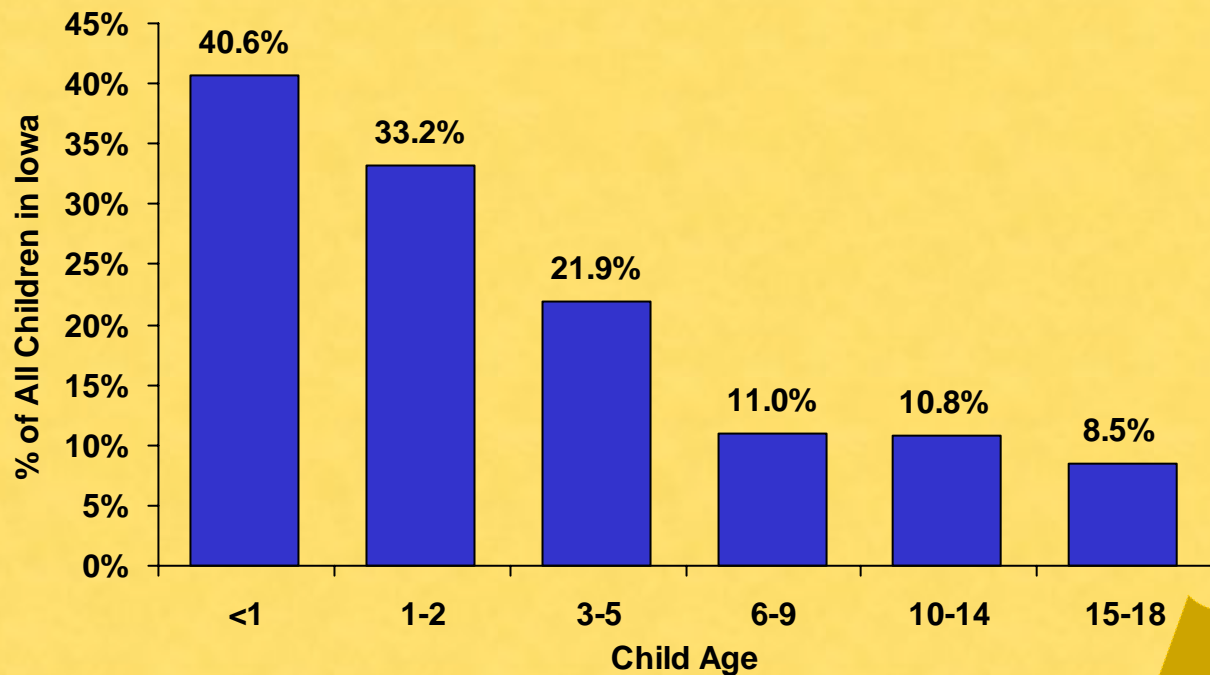
- **New federal policies likely to provide new options to states regarding premiums and co-payments for children that have not been tested but may be tempting to employ as cost-containment measures**
- **New federal policies may eliminate or restrict provisions and protections for children assessed with special needs (under EPSDT) from receiving services to address those needs**
- **Iowa's direction under the Achieving Better Child Development (ABCD) Initiative funded by the Commonwealth Fund should be expanded and that type of model should be promoted federally**
- **Other elements of the Iowa proposal that support health promotion also can serve as national models**

# EPSDT's Major Role in Serving Young Children

## Children Seen for EPSDT Visit Under Iowa Medicaid by Child Age: 2002-03

Note: 80.4% of all 0-5 year-olds as proportion of those below 200% of poverty have EPSDT screens, compared with 34.9% of all 6-17 year-olds.

source: 2000 Census



# Medicaid, SCHIP and Children's Health: Key Points

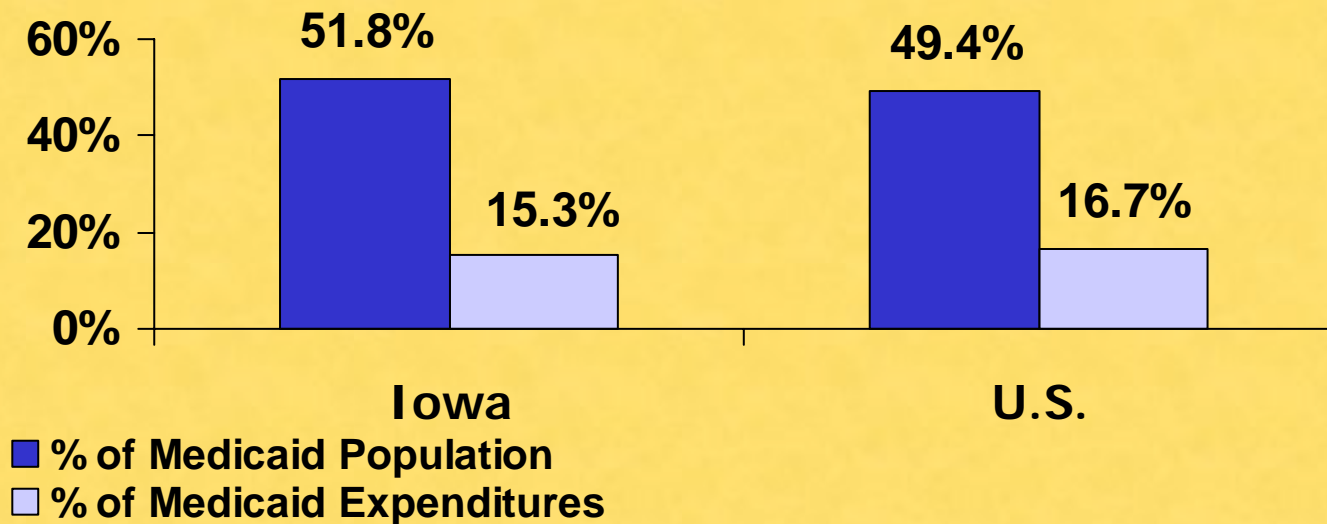
- Children's health coverage would be in a crisis without Medicaid and SCHIP.
- While the majority of the Medicaid population, children represent only a small percentage of Medicaid spending.
- Medicaid and SCHIP play a vital role in providing child health coverage for a large share of the working population.
- Children covered by federal programs (Medicaid and SCHIP) represent those most likely to have significant health needs and require preventive and early intervention services.
- Providing preventive and early intervention health services to young children is cost-effective and needed to achieve societal goals (including closing the achievement gap).

# Children's health coverage would be in a crisis *without* Medicaid and SCHIP.

- Between 2000 and 2004, the costs of employer-based health insurance for families rose from \$6,228 to \$9,516 a 52.8% increase.
- Between 1999 and 2004, as a result of outreach, the recession, and rising health care costs, Medicaid and SCHIP in Iowa expanded by 86.7%
- Between 1998-9 and 2002-3, children's uninsurance in Iowa remained steady (7%), while working-age population uninsurance rose (11% to 14%, seniors remained at 0.4%).

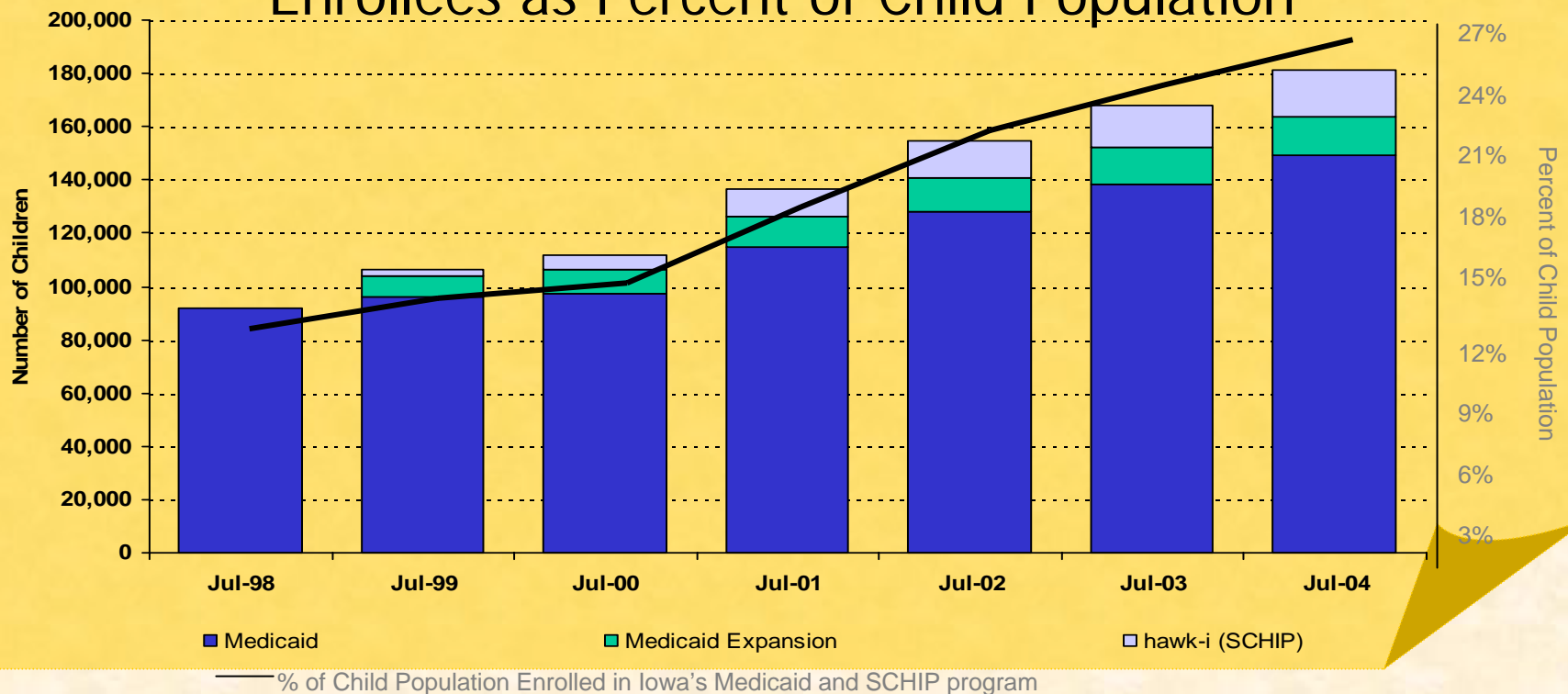
**While the majority of the Medicaid population, children represent only a small percentage of Medicaid spending.**

**Children as Share of Medicaid Population  
and Vender Payments: FFY 2002**



# Medicaid and SCHIP play a vital and growing role in providing child health coverage for a large share of the working population.

## Iowa's Medicaid and SCHIP Program - Enrollees as Percent of Child Population



**Children covered by federal programs (Medicaid and SCHIP) represent those most likely to have significant health needs and require preventive and early intervention services.**

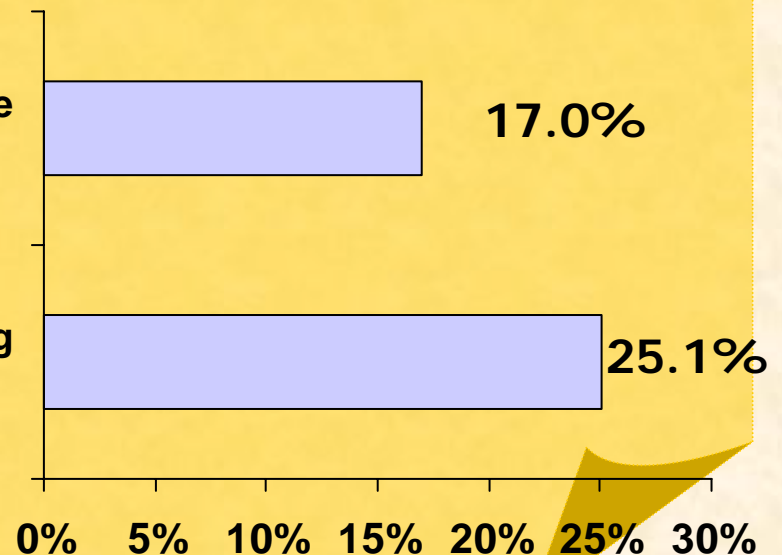
**Chronic Condition Prevalence  
Among Medicaid Children**

Behavioral	11.8%
Attention	10.2%
Asthma	10.2%
Dental Problems	9.7%
Vision Problems	9.6%
Allergies	9.4%
Chronic Ear Infections	5.8%
Depression	5.4%

*2003 Survey of Iowa Medicaid  
Managed Care Enrollees by  
Public Policy Center, University  
of Iowa*

**Iowa child population as a whole  
with a special health care need**

**% of Medicaid Children qualifying  
with a special health care need**



# Sources for Information:

The Commonwealth Fund

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State Early Childhood Policy Technical Assistance Network

[www.finebynine.org](http://www.finebynine.org)